



NATIONAL HISPANIC INSTITUTE

Medical Authorization Form and Waiver of Liability 2011-2012

STUDENT INFORMATION

Form fields for Student Information: First Name, Middle Name, Last Name, DOB:mo/day/yr, Home Address, City, ST, Country, ZIP

PARENT/GUARDIAN 1 INFORMATION

Form fields for Parent/Guardian 1 Information: Full Name, Home Phone, Work Phone, Cell Phone, Home Address, City, ST, Country, ZIP

PARENT/GUARDIAN 2 INFORMATION

Form fields for Parent/Guardian 2 Information: Full Name, Home Phone, Work Phone, Cell Phone, Home Address, City, ST, Country, ZIP

ALTERNATE EMERGENCY CONTACT INFORMATION

Form fields for Alternate Emergency Contact Information: Full Name, Home Phone, Work Phone, Cell Phone (two entries)

MEDICAL CONDITIONS (List any conditions that may affect the student's ability to participate fully in the program.)

Blank line for Medical Conditions

CURRENT MEDICATIONS (List all medications currently being taken by the student.)

Blank line for Current Medications

PHYSICIAN INFORMATION

Form fields for Physician Information: Physician Name, Clinic Name, Phone, Fax

ATTN: NHI ADMISSIONS, P.O. BOX 220, MAXWELL, TX 78656, USA
512-357-6137 (TEL.); 512-357-2206 (FAX); ADMISSIONS@NHMAIL.COM

INSURANCE INFORMATION (IF AVAILABLE)

Insurance Company	Phone Number	Group Number	Policy Number
Policy Holder's Name	Relationship	Home Phone	Cell Phone
Student Last Name	First Name	MI	

I certify that the above information is true and correct.

I certify that I have fully disclosed any medical, physical, mental, or emotional conditions of my child that may affect his/her ability to participate fully in the program.

I understand that participation in the National Hispanic Institute program may include participation in routine physical exercise. I grant my permission for my child to participate in routine recreational or exercise activities that are part of the National Hispanic Institute programs.

In the event that my child becomes sick or injured during the program, I authorize the National Hispanic Institute to seek appropriate medical treatment and/or hospitalization as ordered or recommended by a qualified physician. This may include, but is not limited to the administration of an anesthetic, laboratory procedures, medical treatment, x-ray examination, or other hospital services. Consent is hereby granted to the attending physician(s), hospital(s), and or clinics to release necessary medical information to our local doctors and for use in claims for insurance coverage.

I accept responsibility for the cost of the cost of such treatment and agree to cooperate with the National Hispanic Institute, its employees or officers, its insurance carriers or other related entities to ensure payment for the cost of treatment.

I hereby release the National Hispanic Institute, its officers, agents, instructors, employees and volunteers for any and all illness, injury or accident incurred or suffered by said son/daughter while traveling to, attendance at, or participation in the program from the time of his/her departure from home until his/her return.

Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date
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